Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JOHN F GARVISH MD
2404 YONKERS SUITE 4
PLANVIEW TX 79072

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-1984-01

MFDR Date Received
APRIL 5, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "When this patient was seen at Moore County Hospital of 6/21/12 the only information that the patient's employer provided for the payment of the patient's claim was to bill them directly. We sent out a claim form to the patient's employer on 7/17/12. On 10/16/122 we again billed the patient's employer for services. On 2/07/13 Texas Mutual responded to our office's bills and this was the first knowledge that there was a worker's comp insurance information and we filed the claim to TX Mutual. However, when Texas Mutual notified our office it was well after the 95 day filing deadline. However, when we filed this claim it was denied as past the filing deadline."

Amount in Dispute: $107.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided radiology services to the claimant on the date above then billed Texas Mutual for this. Texas Mutual received the bill 12/26/12 and denied the bill as untimely. There is no record in Texas Mutual's claim file of a request for reconsideration of the initial denial of payment. This is required by Rules 133.250 and 133.307. The requestor has not exhausted the prescribed administrative remedies before seeking medical fee dispute resolution and so his request must be dismissed.."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 21, 2012	Radiological Services	$107.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29- The time limit for filing has expired.
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service. For services on or after 9/1/05.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation submitted by the requestor finds that the health care provider initially billed the injured workers' employer. According to 28 Texas Administrative Code §133.20(j) the health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following: (1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: (A) prompt payment, as provided by Labor Code §408.027; (B) interest for delayed payment as provided by Labor Code §413.019; and (C) medical dispute resolution as provided by Labor Code §413.031. Therefore, no documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute waives the right to Medical Fee Dispute Resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 23, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.